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Medical Care for the Aged Under MAA and OAA, 1960-63

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MEDICAL CARE FOR THE AGED

UNDER MAA AND OAA, 1960-63

THREE YEARS' EXPERIENCE in providing medical care services for the aged under public assistance programs which were expanded by the Kerr-Mills legislation of 1960 gives a basis for appraisal of the effectiveness of federally aided State public assistance programs in meeting medical care needs.

Public Law 86-778, including the Kerr-Mills amendments to the Social Security Act (a) established a program of medical assistance for the aged (MAA), with Federal aid to the States for medical assistance to older persons not receiving old-age assistance but whose income and resources are insufficient to meet the cost of needed medical care, and (b) provided additional Federal aid to States for payments to suppliers of medical care under existing old-age assistance programs (OAA).

By the end of September 1963, 32 jurisdictions (28 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands) had established medical assistance for the aged programs; 28 jurisdictions had expanded or improved coverage or content of medical care services previously provided under old-age assistance programs; and 11 jurisdictions had begun to make direct payments to suppliers of medical care services for the first time under old-age assistance.

Direct payments to suppliers of medical care (vendor payments) increased 128 percent between 1960 and 1963 for all federally aided public assistance programs. About three-fifths of the increased expenditures were for aged persons under MAA.

Under MAA, the Federal Government shares with States in the total cost of the program; there is no limitation on either the individual payment or total State expenditures. The amount of Federal participation ranges from 50 to 80 percent of medical care expenditures paid to suppliers of medical care in behalf of eligible recipients. The higher percentages go to States with lower per capita income.

States may make available a broad range of medical services. These include: (1) physicians', dental, private duty nursing, physical therapy and related services; (2) inpatient hospital, outpatient hospital or clinic, skilled nursing home, and home health care; (3) laboratory, X-ray, diagnostic, screening, and preventive services; (4) prescribed drugs and appliances including eyeglasses, dentures, and prosthetic

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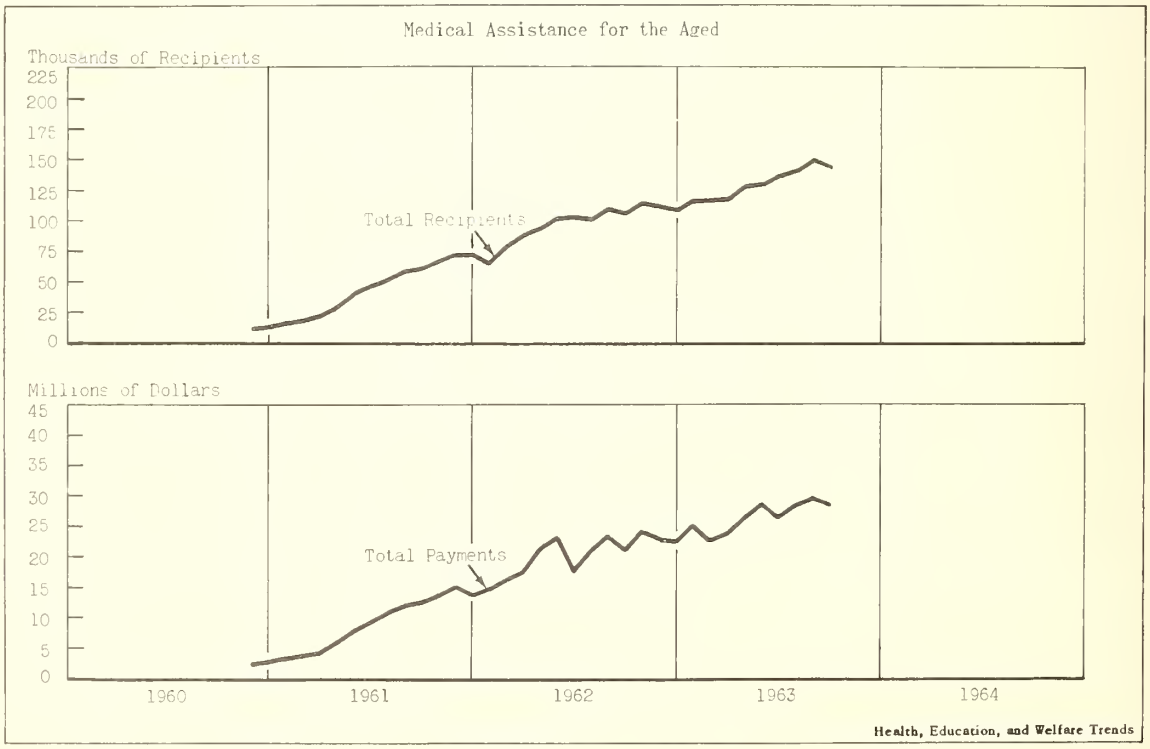
By Helen E. Martz. Dr. Martz is a social welfare adviser in the Bureau of Family Services. Data for 1963 are preliminary and subject to revision.

devices; and (5) any other medical or remedial care recognized under State law. States determine the kinds and extent of services for which costs will be assumed and the conditions of eligibility for such services.

Relatively few conditions are imposed by the Federal act. Some of these are: (1) the State must include some institutional and some non-institutional care; (2) a durational residence requirement is not permitted; (3) no charge, such as an enrollment fee or premium, is permitted as a condition of eligibility; (4) a lien may not be placed against the property of any individual prior to his death on account of medical assistance properly paid in his behalf, and recovery of such assistance cannot be made except from his estate after the death of the surviving spouse, if any; and (5) disclosure of information concerning applicants and recipients is restricted to purposes directly connected with the administration of the program.

In addition to the usual share in old-age assistance payments, the Federal Government under 1961 legislation provides an additional amount based on expenditures for payments to suppliers of medical care up to a monthly maximum averaging $15 per recipient ($12 under the 1960 amendments). The additional funds are intended to enable States to improve or to initiate medical care services in their OAA programs. Amendments to the Social Security Act in 1962 increased from 50 to 75 percent the maximum amount of Federal financial participation that could be made available to States in the cost of rehabilitative and other social services, and provided also for Federal financial participation in the cost of vendor payments for medical care for up to 3 months prior to application.

Figure I



Implementation of MAA

There were 144,033 recipients of MAA in September 1963 in 32 active programs (figure 1). They represented 12 per 1,000 persons aged 65 and over in these States and 8 per 1,000 of all the aged in the United States.

During the first 2 years of the program, nearly one-fourth of the approved cases had been transferred from other assistance programs, primarily in States that had large numbers of old-age assistance recipients requiring costly nursing home care and long-term hospital care. States in which the largest number of transfers occurred were California, Connecticut, Idaho, Massachusetts, Michigan, New York, and North Dakota.

Between October 1, 1960, the effective date of MAA, and September 30, 1963, a total of $596 million was expended under MAA. Of this, $306 million, or 51 percent, came from Federal funds, and $290 million from State and local funds (table 1). Over 74 percent of the expenditures were made by three States (California, Massachusetts, and New York). About 85 percent of MAA expenditures were made either for persons transferred from OAA or other public assistance programs or for persons who would have been eligible for another assistance program insofar as income is concerned if no MAA was available.

There is considerable range among the participating jurisdictions in the number of elderly persons receiving medical care under MAA and in the average payment per recipient. For example, in September 1963 the number aided ranged from 73 in Florida (which had recently initiated its program) to 30,000 in New York. The District of Columbia and Wyoming had programs in operation but made no payments for medical care in September. Over half of the recipients were in three States (California, Massachusetts, and New York). Average MAA payments ranged from $4 in Guam, $7 in the Virgin Islands, and $28 in Kentucky to $419 in Illinois. The average payment per recipient for all jurisdictions was $196. The high average payment areas were widely scattered throughout the country (figure 2).

Table 1. Total expenditures for MAA, by source of funds, Oct. 1960-Sept. 1963

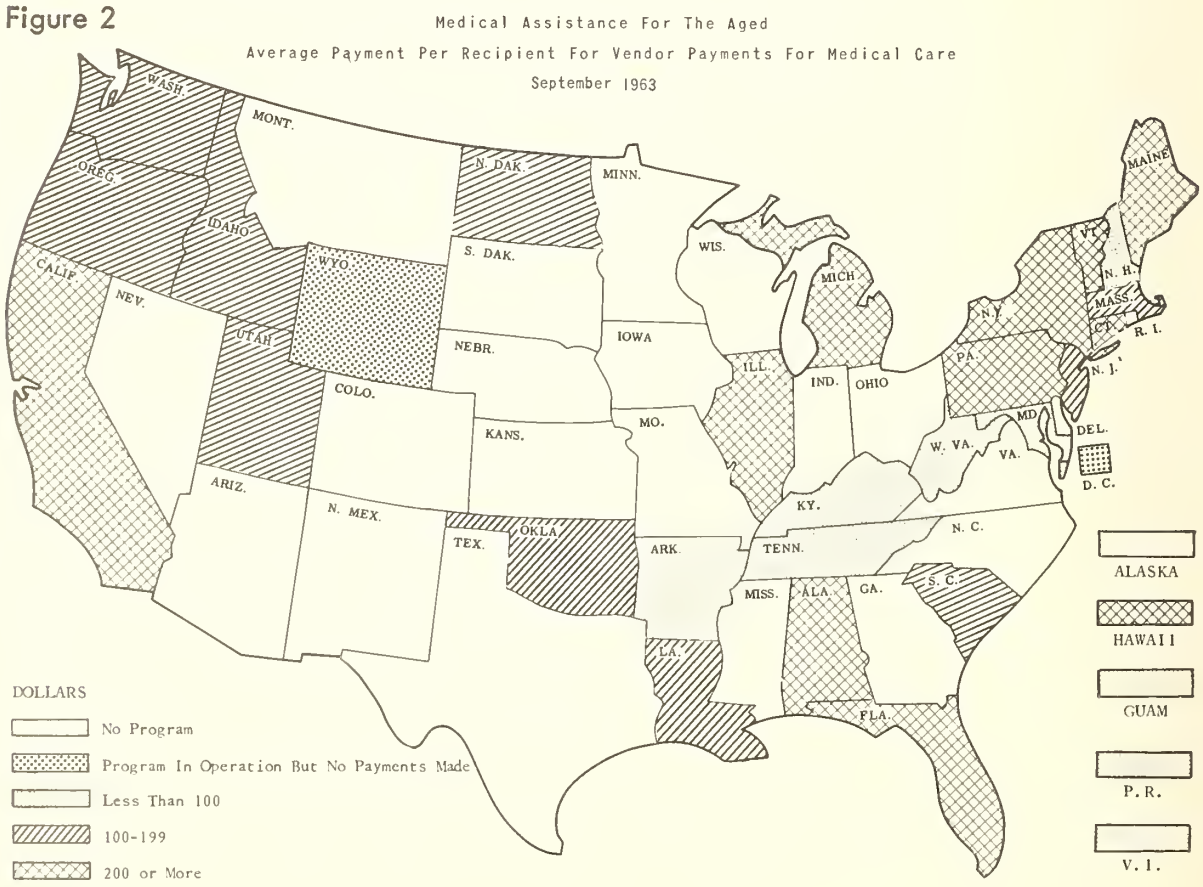
State	Total expenditures (thousands of dollars)		
	Total	Federal	State and local
All States	$596,258	$305,796	$290,462
Alabama	979	766	213
Arkansas	2,078	1,663	415
California	93,348	46,674	46,674
Connecticut 1/	15,816	7,908	7,908
Dist. of Columbia	251	125	126
Florida	53	32	21
Hawaii	2,477	1,238	1,239
Idaho	4,834	3,259	1,575
Illinois	5,980	2,990	2,990
Kentucky	1,654	1,245	409
Louisiana	1,543	1,133	410
Maine	1,710	1,122	588
Maryland	5,419	2,709	2,710
Massachusetts	114,243	57,121	57,122
Michigan	48,574	24,287	24,287
New Hampshire	317	179	138
New Jersey 1/	2,192	1,096	1,096
New York 1/	234,309	117,155	117,154
North Dakota 1/	4,218	3,080	1,138
Oklahoma	3,125	2,052	1,073
Oregon	2,226	1,113	1,113
Pennsylvania	24,528	12,264	12,264
South Carolina	2,524	2,019	505
Tennessee	1,253	947	306
Vermont	272	176	96
Utah	3,416	2,128	1,288
Washington	9,177	4,588	4,589
West Virginia	8,521	6,115	2,406
Wyoming	2/	2/	2/
Guam	14	7	7
Puerto Rico	1,152	576	576
Virgin Islands	56	28	28

1/ Excludes money payments to recipients not subject to Federal matching.
2/ Program in operation but no payments made.

Most jurisdictions began their MAA programs conservatively. By September 1963 only 4 States (Hawaii, Massachusetts, New York, and North Dakota) provided for "comprehensive" programs, that is, programs based on care in each of the five major areas of medical services: physicians' services, dental care, hospitalization, nursing home care, and prescribed drugs. Seven additional jurisdictions gave some care in each of the major areas but with significant limitations on the condition for which care would be provided or the extent of such care, and 14 others provided three or four major services (10 included hospitalization, nursing home care, and practitioners' services) with some limitations on one or more of these. Seven jurisdictions provided only the two minimal institutional and noninstitutional services required by law. All 32 jurisdictions included inpatient hospital care; 30, physicians' services; 22 nursing home care; 15, dental care; and 17, drugs.

About 47 percent of the expenditures made in MAA during fiscal 1963 were for hospitalization--a service provided in all jurisdictions with programs. While only two-thirds of the jurisdictions included nursing home care under their MAA programs, expenditures for nursing home care were higher than for hospital care. Hospital care and nursing home care costs combined accounted for 94 percent of total MAA expenditures; about 2 percent of expenditures were for physicians' services, 2 percent for prescribed drugs, and 1 percent for all other services.

Figure 2



Basis of Financial Eligibility for MAA

In more than half the 32 jurisdictions, persons eligible for MAA who have health insurance or other potential resources covering services provided by MAA must use the resources before payment is made under MAA. Five jurisdictions include a deductible feature--an amount which must have been obligated by an individual in a year for medical care before he can be eligible for MAA.

In determining financial eligibility for MAA, the consideration given to income and other resources also varies among States. For example:

1. Most jurisdictions use a specified level of income in determining financial eligibility. In 10 jurisdictions, the income figure represents the amount considered as needed for living expenses, and income or available assets beyond that amount are evaluated against the cost of medical care received by the individual. The most liberal annual income level used by a State is $2,400 for a single person, although one State goes up to $3,000 in relation to hospital costs only; the most common income level is $1,500.

2. Twenty-nine of the 32 jurisdictions exclude life insurance from consideration as an asset under specified conditions, such as, in 14 jurisdictions, within a dollar maximum ranging from $500 to $3,000 with $1,000 the usual limit, and in 12 jurisdictions, within the dollar maximum for all personal property. Three jurisdictions consider as a resource the full loan value available from insurance.

3. All 32 jurisdictions take into account the availability of other personal property to meet medical care costs. In 29, there are dollar limits on the amount that may be held without affecting eligibility. These range from $50 to $2,800, with most between $1,000 and $2,500.

4. All jurisdictions exempt real property used as a home, but six require that equity in the home not exceed a stated amount. One jurisdiction does not allow holding other real property, one permits it only if encumbered, and seven require it to be income-producing or developed into a resource that can be applied toward medical care costs. Of the other 23 jurisdictions, some require the value of other real property in excess of certain limits to be applied to medical costs, and others specify limits on the value of such property which may be held.

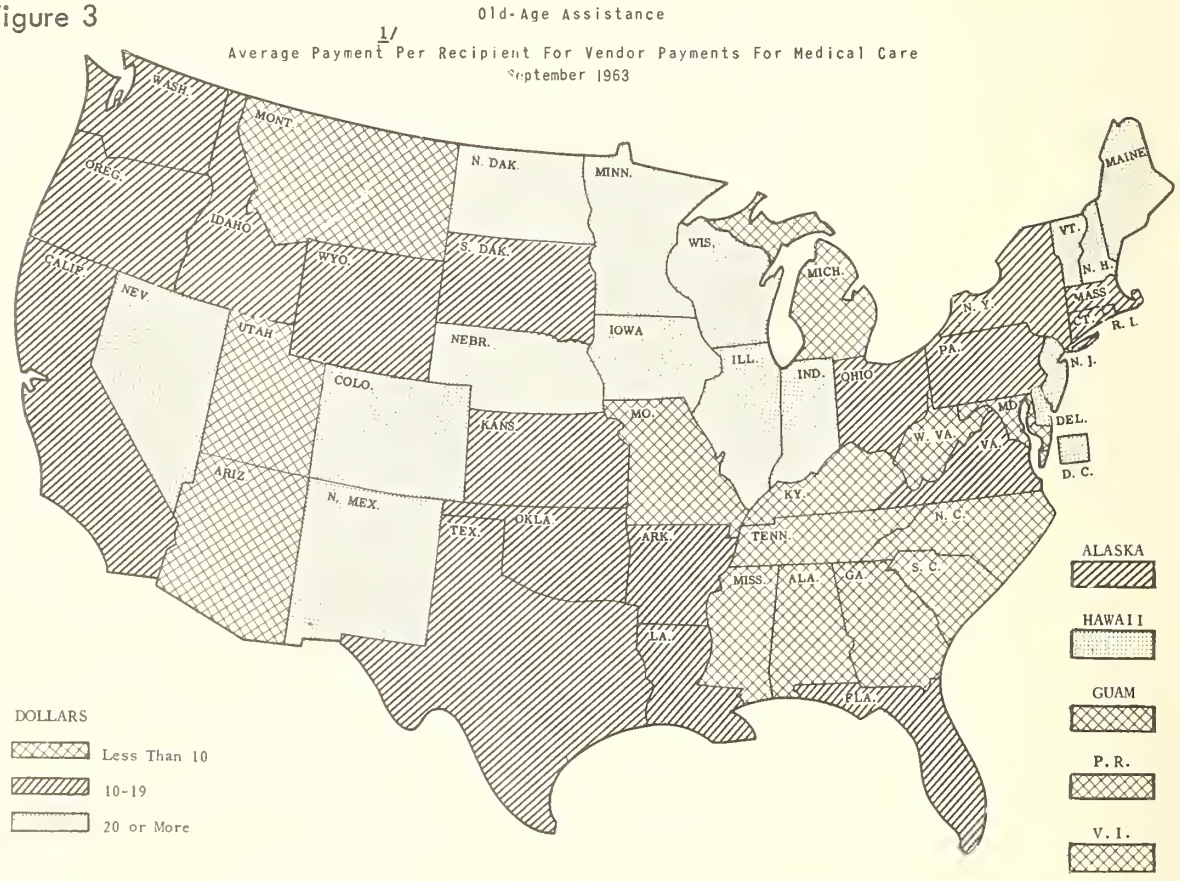
Extended Medical Care Provisions Under OAA

All 54 jurisdictions made vendor payments for medical care services for OAA recipients in September 1963. Increased funds under the Kerr-Mills legislation enabled 11 jurisdictions which had no vendor payment programs for OAA recipients before September 1960 to incorporate such provisions. Twenty-eight jurisdictions which already had vendor payment programs made their programs more comprehensive.

In fiscal 1962, 1.3 million OAA recipients--about half of all those who received OAA--received one or more types of medical or remedial care through vendor payments. The national average vendor payment for medical care per recipient of old-age assistance for medical care increased from $11 in September 1960 to $15 in September 1963 (this average is based on total caseload, including OAA recipients who did not receive medical care). Average payments in the individual States for all OAA recipients ranged from a low of 1 cent in Montana (where only costs related to remedial eye care are met) and 93 cents in Puerto Rico to a high of $74 in Wisconsin. States with a high average vendor payment for medical care were largely concentrated in the northeast, north central, and the Pacific northwest areas. Averages were generally low in the southeast and the territories (figure 3).

By September 1963, 21 jurisdictions provided a relatively comprehensive scope of services. Sixteen made vendor payments in each of the five major kinds of medical care (physicians' services, dental care, hospitalization, nursing home care, and prescribed drugs), and five used the vendor payment method for four services and the money payment for nursing home care.

Figure 3



1/ Averages are based on all cases receiving assistance whether in the form of money payments alone, vendor payments for medical care, or both.

Of the other 33 jurisdictions providing vendor medical care payments, 9 provided four of the major services; 2 provided three of the major services plus money payments for nursing home care and one other service; 5 provided hospital and nursing home care plus other physicians' services or prescribed drugs; 15 provided one or two of the major services, usually hospitalization; and 2 provided only nursing home care.

In fiscal 1962, more OAA recipients (roughly three-fourths) received physicians' services than any other type of care. Three-fifths received drugs, and one-fourth, hospital care.

Federal-State Cooperation

The 1960 legislation gave the Secretary of Health, Education, and Welfare responsibility for (1) developing and revising guides and recommended standards as to the level, content, and quality of medical care services for use by States in evaluating and improving their medical care provisions; (2) securing periodic reports from the States on items included in and the quality of medical care and services for which expenditures are made; and (3) publishing data secured from these reports and other information. These functions were delegated to the Bureau of Family Services in the Welfare Administration (formerly the Bureau of Public Assistance in the Social Security Administration).

Since enactment of the Kerr-Mills legislation, the Bureau of Family Services has strengthened its medical care resources to assist the States in the development of State legislation and other planning necessary to put the new medical care provisions into effect. A new Division of Medical Care Standards was established in the Bureau in 1961 with responsibility for developing guide materials and recommended standards and for providing consultation in the medical care services and health plans of State public assistance agencies. A medical advisory group, including physicians and specialists in paramedical areas, was also appointed to advise the Bureau on specific problems relating to medical needs and services to needy people.

The medical advisory group usually meets twice a year to assist in the development of medical care guide materials and standards. In addition, consultants make factfinding and consultative trips to States in connection with administrative and program aspects of medical care, and a subcommittee advises the Bureau in the selection of medical care areas for special study. One regional meeting has been held and additional meetings are being planned with the American Hospital Association to promote closer working relationships between staff of both agencies.

Guide materials and recommended standards prepared and issued by the Bureau of Family Services to help States expand and strengthen their medical care programs include such publications as "Financial Eligibility: Medical Assistance for the Aged"; "Casework Services in Public Assistance Medical Care"; "Reports on Cooperative Action Between State and Local Health and Welfare Agencies"; "Sketches on Working with the Sick and Disabled"; "Medical Care in Public Assistance, Organization and Administra-

tion"; "Home Health Care Services"; "Pharmaceutical Services"; and "Dental Services." An informational leaflet "Medical Care for Older Persons" was prepared, and pertinent materials issued by other groups were distributed by the Bureau to States, including "Medical Assistance for the Aged and Nursing Services in the Home," prepared jointly by the Bureau and the Public Health Service and issued by the Public Health Service; "Your Nursing Services Today and Tomorrow," Public Affairs Pamphlet No. 307; and "Guides for Drug Expenditures for Welfare Recipients," prepared jointly by the American Public Welfare Association and the American Medical Association.

Other guides and recommended standards are being developed by the Bureau in such areas as physicians' services, optical services, hospital services, nursing home services, advisory committees, rehabilitation, and data collection and evaluation. A preliminary study has also been made of health insurance policies and experiences in providing health services for public assistance recipients. No State agency by September 1963 had used Blue Cross or a commercial prepayment insurance plan to implement its MAA program.

States similarly intensified their efforts to strengthen their medical care resources, and 42 of the 54 jurisdictions have taken steps toward implementing the Kerr-Mills provision for MAA. During the 3-year period, all but three jurisdictions (Alaska, Delaware, and Mississippi) took necessary steps to provide legislative authority for such a program, and of those that took such steps, all but nine (Arizona, Colorado, Indiana, Missouri, Montana, Nevada, Ohio, Rhode Island, and Texas) obtained it. In addition to the 32 jurisdictions that now make MAA payments, another (Iowa) started a program in December 1963, three (Virginia, Kansas, and Nebraska) began programs in January 1964, and two (Minnesota and Wisconsin) plan to initiate programs after July 1, 1964. Enabling legislation in one State (North Carolina) has not yet been implemented, a MAA plan is in process in one jurisdiction (South Dakota), and two (Georgia and New Mexico) have not obtained funds to implement their legislation.

States have also increased their efforts to utilize more professionally qualified staff to carry their increasing responsibilities in medical care. Staff specifically identified with medical assistance and medical care activity increased gradually between 1950 and 1960 but has grown rapidly since then. Today, more than 20 jurisdictions have established full-time positions for physicians, many as medical care program directors. Most jurisdictions have one or more well-trained medical social workers on their staffs. Pharmacists are employed by some agencies, one State has a full-time dentist, and other paramedical personnel are also being used. All jurisdictions have medical advisory committees.

Meeting Medical Care Needs Under Public Assistance

Persons aged 65 and over make up 9.4 percent of the total population of the United States; their number is growing at the rate of over 1,000 a day. Their need for more health facilities and medical services is also increasing.

Since advancing age is accompanied by a decline in both physical and earning capacity, health problems and ability to pay for needed medical care are of major concern to the aged. Moreover, fewer older persons than younger persons are covered by health insurance, and those older persons who do have insurance often have less comprehensive coverage.

As described earlier, under the Kerr-Mills legislation, between September 1960 and September 1963, 28 jurisdictions extended their medical care provisions under old-age assistance, and 11 included vendor payments for medical services for the first time. The average monthly vendor payment per recipient under old-age assistance increased from $11 in September 1960 to $15 in September 1963. More of the medically needy aged are also being reached under newly established MAA programs--144,033 received MAA in 32 jurisdictions in September 1963. The average monthly payment was $196 for that month. Together, in fiscal 1962 the two programs of OAA and MAA provided some vendor medical care for 1.5 million recipients, or 85 per 1,000 of the estimated population aged 65 and over.

Table 2. Vendor payments for medical care under public assistance programs

Federally aided program	Payments (dollars)	
	Total fiscal 1963 (millions)	Average per recipient September 1963 1/
All programs	898	--
Old-age assistance	411	15
Medical assistance for the aged	287	196
Aid to families with dependent children	101	2
Aid to the permanently and totally disabled	88	18
Aid to the blind	11	9

1/ The figure for the MAA program includes primarily persons in whose behalf vendor payments for medical care were made in the month. The averages for the other programs are based on all cases receiving assistance whether in the form of money payments alone, vendor payments for medical care, or both.

Payments to suppliers of medical care for aged recipients of public assistance more than doubled between October 1960 and September 1963. Of the total expenditure of $898 million in fiscal year 1963 for medical vendor payments under all the federally aided public assistance programs, $411 million was expended under old-age assistance, and $287 million under medical assistance for the aged (table 2).

Yet even with this expansion, the extent to which States are reaching into the total group of medically indigent aged persons is limited. For example, more than one-third of the total aged population reside in the jurisdictions which did not yet have MAA programs in operation in September 1963. The basis on which financial eligibility for MAA is determined by the different jurisdictions is only slightly higher than for OAA. Only four MAA programs provide comprehensive care in each of the five major areas of medical services.

Although 78 percent of all vendor payments for medical care under Federal-State assistance programs were for aged recipients in fiscal 1963, the benefits of the MAA program are reaching a relatively small segment of the Nation's elderly, and this segment is concentrated in several States--over half of the MAA recipients resided in three States in September 1963, and more than three-fifths (62.4 percent) of MAA expenditures were made by three States. Variation between States remains wide.

The relatively limited State funds available to finance the costs of

medical care, even with the liberal help of Federal grants under the Kerr-Mills legislation, has, of necessity, resulted in a variety of limitations similar to those utilized in the other public assistance programs--limits on income and resources, consideration of family responsibility, recovery provisions, and various eligibility conditions.

Thus, 3 years' experience has pointed up both limitations and strengths of public assistance programs in attempting to meet medical care needs of the aged. As in all grant-in-aid assistance programs, the State has responsibility for initiating a program and for determining its coverage and the quantity and kind of care provided. The Federal Government provides technical consultation and encouragement and reviews State plan material to assure that a proposed program conforms to the Social Security Act. But the pace of development of the program is ultimately dependent upon State action, which in turn depends on availability of State funds and a willingness to use them for medical care needs in view of other demands for services.

The liberally drawn measure passed by Congress in 1960 has not yet realized its full potential in large measure because of lack of State financing and partly because of uncertainty about future costs. But it took 20 years for all States to establish programs of aid to families with dependent children, and 13 years after authorization of the aid to the permanently and totally disabled program, all States have not yet established such a program for their needy disabled.

MAA is just 3 years old. Despite fiscal and other problems, some States have made considerable progress in extending help to the needy aged in meeting their medical care needs. With time and experience, more States will probably extend their MAA programs, and others may establish new programs. But the cost factor continues to be an important consideration in making use of the full potentials of the Kerr-Mills legislation. With a backstop of social insurance for costly items of medical services such as hospital care, MAA could undoubtedly enable States to meet more adequately other medical care needs of the aged.

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